

TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, February 27, 1907.

The President, DR. GEORGE WOOLSEY, in the Chair.

GASTRO-ENTEROSTOMY WITH THE ROOSEVELT CLAMP.

DR. JOHN F. ERDMANN presented a man, fifty-two years old, a glazier by occupation, whose family history was unimportant. He had been under treatment at the Vanderbilt Clinic for some time for stomach trouble which consisted essentially of a feeling of heaviness coming on about two hours after each meal. He could usually be relieved by sodium bicarbonate.

In the early part of September, 1906, the patient was taken with one of these attacks, which, however, failed to subside, and steadily grew worse. In addition to his usual symptoms, attacks of vomiting developed, generally coming on about three hours after meals and sometimes during the night. By these attacks of vomiting, and also by lavage, his gastric pain was relieved. The patient gradually became weak, and lost about 25 pounds in three months. He had some aversion to meat, but his appetite was but slightly impaired. His bowels were somewhat constipated.

Physical examination: The patient was pale, but not cachectic. Heart and lungs negative. There was slight resistance over the stomach region. The pylorus was not palpable. The liver and spleen were negative. Urine negative. An examination of the stomach contents after a test breakfast gave the following results: Free hydrochloric acid, 36; total acidity, 60. No lactic acid; starch digestion, poor. The lower border of the stomach was at the navel; the upper border at its normal level. Motility of the stomach was much impaired. In the morning, on emptying the stomach, the organ contained about 1 pint of foul-smelling rancid food. A microscopical examination of the stomach washings

showed starch, some fat, mucus, little round cells, numerous bacteria.

The patient was operated on January 5, 1907. Upon exposure of the stomach and pylorus no evidences of malignancy were observed, but in the first portion of the duodenum a nodular mass, about the size of an egg, was found. This was located about 1 inch from the pylorus, and, on account of the dense adhesions, it was deemed inadvisable to remove it. A posterior gastro-enterostomy was thereupon done with the Roosevelt clamp. The patient made a slow but positive recovery from the operation, and up to the present time had gained about 20 pounds in weight.

Dr. Erdmann demonstrated the Roosevelt clamp. The instrument consists of a three-bladed clamp by means of which the tissues of the stomach and intestinal wall can be grasped and sutured with remarkable ease.

CHOLECYSTOTOMY FOR PANCREATITIS,

DR. JOHN F. ERDMANN presented a man, thirty-four years old, who was referred to him by Dr. Titus Bull on December 15, 1906. The history was that the patient was taken ill eight or nine weeks ago with sharp pain in the abdomen, followed by jaundice, pain in the back and some itching of the skin. The history stated that he had had similar attacks five years ago. He always had pain in his stomach, which was worse immediately after taking food. There was an occasional history of vomiting, and he stated that he had recently twice vomited dark, coffee-colored stuff. His present weight was 147 pounds, which represented a loss of 41 pounds since the previous spring.

Examination showed a patient 6 feet, 2 inches tall, markedly emaciated, with an extremely sensitive area covering the epigastric and both hypochondriac spaces. There was gastrectasia and gastroptosis.

Operation, December 18, 1906: Upon opening the abdomen, the stomach showed no evidences of malignancy or ulcer. The pylorus, gall-bladder and common duct were negative. Involving the pancreas there were two large masses, one in the head, about the size of a tangerine orange; the other in the tail, the size of a hen's egg. An attempt was made to remove a section of the large mass in the head, but it was accompanied by such profuse bleeding, with such difficulty in controlling it, that the

idea was abandoned. A cholecystotomy was thereupon done, and when the patient left the hospital, four weeks later, his general condition was excellent. Within seven weeks after the operation he had gained 35 pounds in weight, of which 30 were gained since he left the hospital. No calculus was found in the gall-bladder.

ABSCESS OF THE PANCREAS.

DR. GEORGE E. BREWER presented a woman, forty-eight years old, whose illness began with an attack of pain in the upper part of the abdomen, with fever and general prostration. She was admitted to the medical division of the Roosevelt Hospital, at which time she presented all the evidences of an epigastric peritonitis. The chief point of pain and tenderness was just to the left of the median line, midway between the ensiform and umbilicus. No diagnosis was made, but under expectant treatment the patient apparently improved. When she attempted to get out of bed, however, the pain and tenderness recurred, without any marked rise of temperature, and the patient was referred to the surgical division for exploratory operation.

On opening the abdomen, the stomach, the spleen and the transverse colon were found united by dense adhesions. The central portion of the pancreas seemed enlarged and indurated, and a needle introduced through the transverse mesocolon entered a cavity and withdrew creamy pus. The abscess was then opened by thrusting a pair of dressing forceps into the gland and withdrawing them partly open. The cavity was then explored with the finger, and was found to be limited to the pancreas. About 2 ounces of pus were evacuated. A large-sized drainage tube, about half an inch in diameter, was then introduced into the abscess cavity, and held there by single catgut suture. Gauze tape was packed around it to prevent any leakage of pus into the peritoneal cavity. The tube and gauze were allowed to pass downward along the posterior portion of the abdominal cavity, and were finally brought out at the lower angle of the abdominal wound. This allowed the transverse colon to fall into its normal position, and prevented any kinking by the tube.

For the first two days after the operation there was a very free discharge from the tube, after which it gradually ceased. While the external dressings were frequently changed, the tube was not disturbed for eight or ten days, when it was removed,

together with the gauze tape. The wound then promptly closed.

Practically, no reaction followed the operation, and the patient made an uninterrupted recovery. Upon examination, the pus showed a pure culture of para-typhoid bacillus.

DR. WOOLSEY said that in three cases of acute pancreatitis, where he had been called upon to operate, he had in each case expected an abscess, but in none of them did an abscess form. Nothing was done to the pancreas but to relieve the tension by a median abdominal incision, evacuation, irrigation, and drainage. The speaker said that Hahn had advised the same method of treatment, and had not found necrosis to follow.

TIC DOULOUREUX: SECTION OF THE SECOND AND THIRD
DIVISIONS, WITH INTERPOSITION
OF RUBBER TISSUE.

DR. BREWER presented a woman, fifty-four years old, who was admitted to the Roosevelt Hospital in October, 1904. She had suffered for eleven years with facial neuralgia, the pain being situated in the second and third divisions of the fifth nerve. At times the pain had been intense, and was associated with spasmodic contractions of the muscles. During the three months previous to her operation she had suffered intensely. She had great difficulty in taking food, and had lost sixteen pounds in weight.

Operation: The ganglion was exposed by the Hartley incision, the second and third divisions of the nerve were divided, and a folded piece of rubber tissue interposed between the divided ends. The patient made an uninterrupted recovery, and had not suffered a single twinge of pain since the operation, which was done two years and five months ago.

EPITHELIOMA OF THE LARYNX: LARYNGECTOMY.

DR. BREWER presented a man fifty-eight years old, who was admitted to the Roosevelt Hospital in August, 1905, suffering from a small epithelioma which was situated on the right vocal cord. Under ether anæsthesia a low tracheotomy was done, after which, with the patient in the Trendelenburg position, the cavity of the larynx was exposed by a median fissure, and the entire growth, together with both vocal cords and the surrounding mucous membrane and the submucous tissue, were completely removed down

to the cartilage. The laryngeal fissure was then closed by two or three sutures of catgut, and a tracheal tube allowed to remain in place. The tube was removed on the fourth or fifth day, and the patient was able to leave the hospital on the fourteenth day. He remained well for several months, but when he returned to the hospital, in March, 1906, there were evidences of a distinct recurrence. A total laryngectomy was thereupon advised, and was performed in two stages. The first operation consisted in a section of the trachea just below the cricoid, separation of the upper segment from the œsophagus, and stitching it to the cutaneous opening. Three weeks later the larynx was removed in the usual manner. Recovery was uneventful. It was now ten months since the operation, and there were no signs of a recurrence. The delay between the first and second stage of the operation was due to a broncho-pneumonia following the first division of the trachea.

DR. BREWER presented, also, a woman, thirty-one years old, who was admitted to the Roosevelt Hospital early in January, 1907. For eighteen months she had suffered from hoarseness, slight cough and aphonia. Laryngoscopic examination showed an infiltrating growth involving both vocal cords, the commissure, and extending well into the subglottic space. A fragment of the growth removed for microscopic examination showed nothing characteristic. Vigorous treatment with potassium iodide for three months was without result. Thyrotomy, with removal of a large section of the growth and the immediate examination of the frozen section likewise gave an uncertain result. A tracheotomy was then done, and the tissue sent to the laboratory for examination. The final report was that the growth was a characteristic and very cellular epithelioma. Two weeks from the date of the tracheotomy and thyrotomy, the larynx was removed under ether anæsthesia. Gluck's nasal feeding tube was introduced, and kept in place for sixteen days. The patient made an uneventful recovery.

DR. ERDMANN said that in one case of laryngectomy which he showed in connection with a series of these cases some years ago, the patient was still alive and well three and a half years after the operation. In that case, the patient wore a tracheotomy tube that was short and almost straight, with the idea that such a tube would be less apt to give rise to irritation than a long tube.

DR. WOOLSEY recalled the following case, that occurred at Roosevelt Hospital some years ago: A man, who was wearing a tracheotomy tube for laryngeal diphtheria, while apparently convalescing ten days or so after the operation, had a sudden hæmorrhage and was drowned in his own blood. At the autopsy it was found that the tracheotomy tube, which was fairly long and somewhat curved forward at its lower end, had ulcerated through the trachea into the innominate vein, thus causing a fatal hæmorrhage.

PRIMARY TYPHLITIS WITHOUT APPENDICITIS.

DR. CLARENCE A. McWILLIAMS read a paper with the above title, for while see page 852.

DR. IRVING S. HAYNES said he could recall several cases of supposed appendicitis, where, after a careful examination, he had concluded that the involvement of the appendix was a secondary affair, and that the primary source of the trouble lay in the cæcum and colon. In those cases, he had advocated delaying operation, and the cases had recovered without it. In differentiating such cases from appendicitis he had usually found that they had a much higher initial temperature and a corresponding pulse rate, which was probably due to the rapid absorption of toxic products from the large inflamed areas in the cæcum and ascending colon. The abdominal pain, while on the right side, was more diffused than that usually observed in appendicitis, and could be located with less exactness, and on palpation, while the region of the appendix was tender, it was not more so than the whole length of the ascending colon. The speaker said that in one such case where he was induced to operate he found the conditions described by Dr. McWilliams. There were distinct evidences of congestion of the blood vessels in the cæcum, and some thickening of its walls. The appendix, which was about $1\frac{1}{2}$ inches long, less than $\frac{1}{8}$ inch in diameter and only slightly involved, was removed, and the case went on to recovery.

In concluding his remarks, Dr. Haynes said that while at times it might jeopardize the life of the patient by refraining from operation in our attempts to differentiate between typhlitis and appendicitis, still there were cases where the pathological changes were very pronounced in the cæcum and ascending colon, and less so in the appendix. Some of these typhlitis cases

demanding operative interference, while in others an operation could be safely withheld. However, in all doubtful cases it is better to operate.

DR. ERDMANN recalled to mind two cases, one of which was operated on about four years ago, and the other at the Gouverneur Hospital last April. The latter case was that of a bartender, thirty-four years old, who had long been a hard drinker. He gave a history of indigestion and some pain in the stomach, followed by a sudden, sharp attack of abdominal pain. He was kept under observation on the medical side for two days, and then developed evidences of peritonitis, with a markedly distended abdomen. Upon opening the abdomen on the right side, a perforation of the cæcum was discovered. There were no evidences of infiltration, such as are found in typhoidal, tubercular or malignant conditions. The man died of delirium tremens five days after the operation.

The other case referred to was that of a woman who had a tumor in the right side of the abdomen which was at first supposed to be connected with a floating kidney, and malignant in character. She gave an indefinite history of digestive disturbance. Upon opening the abdomen, a large mass was encountered. It apparently sprang from the cæcum and involved the entire ascending colon, and looked so formidable that an attempt to remove it was deemed unjustifiable. An anastomosis was thereupon done between the ileum and the sigmoid, the woman making an uneventful recovery. The operation was done about four years ago. The patient was still alive and well; she had gained about 40 pounds in weight, and the intra-abdominal mass had almost entirely disappeared. It was probably of inflammatory origin.

DR. BREWER said that some years ago he reported a case of complete spontaneous intussusception of the appendix into the cæcum. The latter was the seat of a distinct chronic inflammation, with a marked stricture just above the ileocaecal junction. The cæcum was much distended, and, upon opening it, there were a number of ulcerations such as Dr. McWilliams had described. The patient was operated on twice. At the first operation nothing was discovered but an acute typhlitis, and at the second operation the intussusception of the appendix was found.

DR. CHARLES N. DOWD said that he had been much puzzled during the past two years by some cases of retroperitoneal abscess occurring on the right side, and believed that an inflammation

extending from the cæcum or ascending colon would explain the etiology of a certain part of these cases. He had seen two which were apparently due to broken down hæmatomas. One he believed definitely to have extended from a tubercular intestine, since there was a fæcal fistula. Two others he thought were best explained on the hypothesis of an inflammation similar to that which Dr. McWilliams had referred to. Inflammations which were neither tubercular nor cancerous, certainly appear in other parts of the colon, particularly in the region of the sigmoid flexure, where they were sometimes the occasion of thickening and partial or complete obstruction, and it is fair to believe that a similar inflammation may exist in the cæcum, possibly more often than we have supposed, since appendicitis has been found to explain so much.

DR. JOHN A. HARTWELL said he had seen a case similar to the one referred to by Dr. Erdmann, where the conditions met with gave rise to the suspicion of a malignant growth. The patient was an Italian who was admitted to Bellevue Hospital in 1904 and treated on the medical side for some time for supposed fæcal impaction. Examination showed a distinct mass on the right side of the abdomen. An exploratory incision showed an ulcer, about the size of a silver quarter; it was situated on the anterior surface of the cæcum, and surrounded with marked infiltration and thickening of the entire wall of the gut. The growth was regarded as malignant, and a resection was done, and an anastomosis with the button. A subsequent pathological examination proved that the condition was one of simple inflammation, extending throughout the whole cæcum. On the sixth day after the operation, the patient had a severe coughing spell, and died. No autopsy was permitted.

DR. BREWER said that in the case just reported by Dr. Hartwell, the condition was originally regarded as one of fæcal impaction, and in several of Dr. McWilliams' cases reference was made to ulcerations due to possible pressure of the cæcum. As bearing on that point, Dr. Brewer raised the query whether any one had ever seen solid fæces in the cæcum? Personally, he had never seen it, and he thought we could practically exclude such a condition as fæcal impaction in the cæcum.

DR. WOOLSEY said that about two years ago he operated on a woman who gave all the local and general signs of an appen-

dicitis, with abscess. Upon opening the abdomen, the appendix was found practically normal; but there was a great deal of thickening not only of the cæcum but higher up behind the ascending colon. Behind the cæcum there were multiple abscesses which extended up for some distance behind the ascending colon. The patient made a protracted convalescence, but finally recovered. Cases were occasionally met with, Dr. Woolsey said, in which the symptoms could not be attributed to the condition found in the appendix. Two or three years ago Dr. Blake read a paper before the Society in which he explained some of these cases on the ground of malposition of the appendix, congenital or acquired, dragging the cæcum out of position. Others of them might be explained in accordance with Dr. McWilliams' paper.

DR. MCWILLIAMS, in closing, said it was very difficult to explain the presence of these ulcerations in the cæcum. In most of the cases reported there were no hardened fæces in the cæcum; but there were a few cases on record, especially in patients well advanced in life, where that factor was referred to. In his own cases, the speaker said, there were no fæces whatever in the cæcum. The pathology of the cæcum was not well understood. Possibly, its dependent position might have something to do with it, and foreign bodies projected into it may cause abrasions of the mucous membrane. It was just as difficult to explain analogous ulcerations of the sigmoid, which were very frequent.

In his paper, Dr. McWilliams said, he confined himself to inflammatory conditions limited to the cæcum, and did not intend to include cases of general colitis. A lengthy discussion was opened by Dieulafoy before the Académie de Médecine (reported in the *Revue de Chir.*, 1906, Nos. vii-viii, p. 186 and 301) appertaining to the relation between mucomembranous typhlocolitis and appendicitis.

It would be no easy matter to differentiate peritonitis due to inflammation involving the cæcum and the ascending colon from peritonitis due to an appendicitis. In doubtful cases, an operation should be resorted to.

LIGATURE OF THE INNOMINATE ARTERY.

DR. B. FARQUHAR CURTIS reported this case and showed the specimen. The patient was a man, fifty-nine years old, a native of Germany and a carpenter by occupation. He was admitted

to St. Luke's Hospital on January 4, 1907, with an aneurism of the right subclavian artery.

Operation, January 11, 1907: The manubrium was split to a point below the second rib and the two halves forcibly separated a distance of $1\frac{1}{2}$ inches. The innominate artery was exposed and ligated with No. 4 chromicized catgut, two strands being laid side by side and tied separately 1 inch from the origin of the vessel. Another double ligature of the same material was placed $\frac{1}{2}$ inch beyond the first distally, and the two threads tied together. The divided bone was then sutured with chromic catgut. No drain was used.

All pulsation ceased in the aneurism, the arm and the right carotid immediately after the operation. Twenty-four hours later, pulsation reappeared in the right external carotid. Patient developed a bronchopneumonia, and died four days after operation.

Autopsy showed an aseptic wound. The persistent cough had caused the bone sutures to yield. Both ligatures lay upon the innominate artery, but the proximal one had been driven forward to the distal one by the forcible impulse of the arterial pulsation. The specimen showed the heart, great vessels, and aneurismal sac. A section through the ligatures and vessel wall at the point of ligation shows the vessel folded in longitudinal pleats, the inner surfaces in contact, the internal coat not ruptured. A clot filled the distal part of the innominate artery, the subclavian, and the aneurismal sac. The origin of the common carotid was also filled with clot, but that vessel was clear at its bifurcation. There was no clot on the cardiac side of the ligature. The vessel wall at the point where the first ligature was tied, and over the space travelled by it in slipping forward, showed no alteration. There was moderate atheroma. The sac was about 5 inches long, 4 inches in diameter, involving the first, second and third parts of the subclavian. It had caused complete absorption of the anterior part of the first rib and the scalenus anticus muscle could be seen inserted into the sac wall where the bone had disappeared. The brachial plexus was stretched tightly over the upper part of the sac. Its lower part encroached upon the apex of the thoracic cavity, displacing the pleura and lung. Considerable amounts of blood clot were found in the mediastinum, having extended downward from the seat of operation. The lung showed a purulent bronchitis and bronchopneumonia.